

## NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-03-1702-01

September 5, 2003

An independent review of the above-referenced case has been completed by a doctor board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by \_\_\_ or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_.

Sincerely,

### CLINICAL HISTORY

This gentleman sustained an injury on \_\_\_\_. There were a number of providers involved in this case and several changes of treating doctors. Imaging studies did not identify any discal pathology. Eventually a meniscal lesion was noted; however, the claimant declined to pursue a surgical solution. The Designated Doctor noted maximum medical improvement; who also noted signs of symptoms magnification and malingering.

### REQUESTED SERVICE(S)

Chronic pain management program. 5x week for 6 weeks.

### DECISION

Deny - the chronic pain program is not clinically indicated.

## RATIONALE/BASIS FOR DECISION

The standard being applied was 'is this reasonable and necessary care for the injury?' There was extensive evaluation and documentation of no specific pathology. Multiple providers were included in the care of this gentleman. There were reported symptom magnification and evidence of malingering. The claimant was seeking a 'cure' when he denied definitive treatment for the knee. Then the question becomes 'is there a reasonable chance that this program will have any efficacy?' The statistics are marginal and in this case, where nothing has helped and there is no spinal pathology, and the goals of the program are to address issues wholly unrelated to treating the compensable injury, this is not reasonable and necessary care for the injury sustained.

Therefore, the prior determination is upheld; in this specific case, a chronic pain program is not reasonable and necessary nor will this moderate or obviate the complaints offered by the claimant.

### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 5<sup>th</sup> day of September 2003.